HEALTH CARE FINANCING ADMINISTRATION

MEDICARE ANNUAL REPORT TO THE CONGRESS

Fiscal Year 1985

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MEDICARE ANNUAL REPORT TO THE CONGRESS Fiscal Year 1985

The following reports are contained in this volume:

- Medicare Annual Report
- Report on Medicare/Medicaid Validation Survey of Hospitals Accredited by the Joint Commission on Accreditation of Hospitals
- Medicare Voluntary Certification Program Report

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INTRODUCTION

This annual report describes the performance of the Medicare program during fiscal year 1985. Section 1875(b) of the Social Security Act mandates an annual report on Medicare activities, and Section 1882(f)(2) requires a report on Medigap activities "no later than July 1, 1982, and periodically as may be appropriate thereafter (but not less often than once every 2 years)."

Section 1881(g) mandates a report on the End-Stage Renal Disease (ESRD) program on each July 1. While that report has been submitted in the past with the annual report on Medicare activities, the 1985 ESRD report and future reports will be submitted separately because of the need to obtain more timely data on that program.

EXECUTIVE SUMMARY

Program Operations

Beneficiaries

As of July 1, 1985, 28.2 million aged persons and 2.9 million disabled persons under 65, a total of 31.1 million, were entitled to hospital insurance (Part A) and/or supplementary medical insurance (Part B). Of the 31.1 million enrollees, 30.6 million had Part A and 30.0 million had Part B. Of beneficiaries age 65 and over, 95 percent were covered by both Part A and Part B; 92 percent of disabled beneficiaries were covered by both parts.

Health Care Resources

As of July 1, 1985, there were 6,707 hospitals participating in Medicare with 1,143,638 beds. There were 6,451 skilled nursing facilities, 5,679 home health agencies, 3,980 independent laboratories, and 1,394 facilities or units providing services to program beneficiaries requiring maintenance dialysis or kidney transplant. Additionally, 428 rural health clinics, 336 ambulatory surgical centers, 72 comprehensive outpatient rehabilitation facilities, and 233 hospices were certified to participate in the program.

Benefit Payments

Medicare paid $47.7 billion in benefits under Part A and $21.8 billion under Part B, a total of $69.5 billion. This represents an increase of 14.3 percent over FY 84 total benefit payments of $60.9 billion ($41.5 billion under Part A and $19.5 billion under Part B). Inpatient hospital care accounted for 94 percent of all Part A payments. Medical insurance payments were predominantly for physician and other Part B suppliers' services, which accounted for 75 percent of Part B payments.

Program Funding

The primary source of hospital insurance financing is contributions, based on earnings, by workers and their employers and by self-employed individuals. The remainder is derived from general revenues and other sources. Supplementary medical insurance is financed by three sources: premium payments from enrollees, contributions from general revenues, and interest on trust fund accumulations.

Claims Processing Performance

Claims received by intermediaries increased to 59.5 million, an increase of 18.1 percent over the FY 84 experience. Claims received by carriers rose at a rate of 18.3 percent, totaling 270.8 million. Overall, the volume of Medicare claims rose 18.2 percent. The average claims processing time for intermediaries increased from 8.4 days to 12.4 days. Carriers showed an increase in yearly average claims processing time from 11.5 days to 14.9 days. The average monthly percentage of bills pending over 30 days for intermediaries increased from 15.0 to 23.9 percent. Carriers' average percentage of bills pending over 30 days increased from 12.1 to 15.3 percent.

Contractor Administrative Costs

The intermediary processed workload increased 17.1 percent over 1984. The total cost increased by 13.7 percent. The unit cost for all operations decreased by 17 cents due to increased productivity by intermediaries. For carriers, the processed workload increased by 18.4 percent, while total cost increased only by 16.2 percent. Total unit cost decreased 5 cents.

Program Administration

Quality and Appropriateness of Care

A major goal of the Medicare program is to assure that beneficiaries receive appropriate health services. The Health Care Financing Administration (HCFA) must also ensure that services are necessary and are performed at the most economical level consistent with good care.

To help meet these goals, HCFA requires that facilities providing health care services to Medicare beneficiaries meet certain health and safety standards before they can receive Medicare payment. To ensure that these standards are met, States conduct annual surveys under contract with the Department of Health and Human Services, including validation and allegation surveys of hospitals accredited by the Joint Committee on Accreditation of Hospitals (JCAH) or the American Osteopathic Association (AOA).

The Tax Equity and Fiscal Responsibility Act (TEFRA) established the utilization and quality control peer review organization (PRO) program to replace the professional standards review organization (PSRO) program. PROs are physician organizations under contract with HCFA to review hospital care given Medicare patients to assure that it meets professionally recognized standards of quality, medical necessity, and appropriateness.

During FY 85, the PRO program was fully implemented. Fifty-four PROs, one in each State, the District of Columbia, Puerto Rico, the Virgin Islands, and the Pacific Territories, were designated and operating.

PRO contracts are awarded on a biennial basis, and current contracts expire in 1986. Program expenditures for this period are set at $322.4 million (apportioned). PRO review was completed for 3,568,484 Medicare discharges during FY 85.

Continuing its second surgical opinion program, in FY 85, HCFA distributed 10.5 million brochures entitled "Thinking of Having Surgery? Think About Getting a Second Opinion."

Operational Reviews

Operational reviews assess the need for policy and operational reforms in vulnerable program areas. To inform HCFA senior management of the financial and operational

implications of policy and management decisions, HCFA staff perform studies of selected program and policy issues through extensive research of in-house information supplemented by additional documentation and onsite review.

Reviews conducted in FY 85 included a review of the peer review organization/fiscal intermediary denial/adjustment process; a review of carrier monitoring of the physician fee freeze; a study of the impact of new rules affecting coverage and reimbursement of services of provider-based physicians; a review of the Cardiac Rehabilitation Program; and a national cardiac pacemaker study.

Intermediary and Carrier Performance
HCFA evaluated the performance of Medicare contractors using the Contractor Performance Evaluation Program (CPEP). In this program, specific standards and criteria were applied to all carriers and intermediaries.

HCFA measured intermediaries in the areas of bill processing, provider reimbursement, contract management, productivity investments, payment safeguards, and beneficiary and provider services. Carriers were measured in the areas of claims processing, contract management, productivity investments, payment safeguards, and beneficiary services.

Both types of contractors were also measured in terms of unit cost of claims processing and timeliness of claims processing.

HCFA monitors the quality of Medicare program administration through an array of payment review and other programs. Areas monitored include the quality of provider cost report settlement by intermediaries; intermediary performance in calculating and adjusting PPS interim rates and bill payment computations. Overpayments that were identified totaled more than $4.8 million.

Other Performance-Improvement Initiatives
In FY 85, HCFA made several improvements in billing procedures. These included an increase in the volume of electronic media claims, nationwide implementation of uniform billing for all inpatient and outpatient institutional provider services, and centralization of direct billing and collection.

HCFA also released standards and procedures for improving beneficiary services provided by carriers.

Reimbursement Controls
Legislative and administrative initiatives were implemented to curtail program cost increases and maintain quality and accessibility to health care services for program beneficiaries.

Public Law 98-369, the Deficit Reduction Act (DEFRA), established a freeze on Medicare reimbursement for physician services effective July 1, 1984, through Septem-

ber 30, 1985, which was subsequently extended through the remainder of 1985, and created a participating physician program. (A participating physician is one who voluntarily signs an agreement to accept assignment for all services provided to Medicare patients during the following 12-month period.)

In FY 85, HCFA received 119,525 agreements from physicians representing 138,179 individuals, or 30 percent of physicians billing Medicare. (Since many hospitals and other groups participated but sent in one agreement for the whole group, the number of individuals is greater than the number of agreements.) Suppliers were represented by 17,822 agreements or 23.8 percent of the total.

DEFRA also provided for the use of carrier fee schedules for payment of clinical diagnostic laboratory tests performed in a physician's office, by an independent laboratory, or by a hospital laboratory for its outpatients.

Home health agency cost limits were revised in FY 85. The revision, effective July 1, 1985, incorporated the first major change in limits methodology since the original limits were promulgated. Changes in the schedule of limits included a more accurate method of identifying and excluding extremely high and low costs from those used to establish the limits. The limits were established at a percentage of mean cost, rather than by the percentile method previously used. With the availability of more accurate cost data, these limits apply to the per visit cost of each discipline, rather than the aggregate cost of all disciplines.

Other reimbursement controls included new guidelines for rental/purchase of durable medical equipment; full implementation of the Medicare Secondary Payer program, including clarification of the Federal Government's subrogation rights; and further improvements in safeguards against improper and excessive utilization of health care services.

Prepaid Health Plans

During FY 85, HCFA continued its emphasis on enrolling Medicare beneficiaries in prepaid health plans such as health maintenance organizations (HMOs) and competitive medical plans (CMPs).

Regulations were published in the Federal Register on January 10, 1985, to implement TEFRA. TEFRA significantly changed the manner in which the Federal Government could do business with the health maintenance organization (HMO) industry.

As a result, almost all risk HMO demonstration projects were converted to TEFRA risk status. In April 1985, 32 demonstration contracts with 300,000 enrollees were converted to TEFRA risk contracts. By the end of FY 85 there was a total of 67 TEFRA risk contracts, and enrollment had grown to 364,397. Payments for benefits under TEFRA risk contracts totaled $415 million.

CMPs have more flexibility in benefit design and organizational structure than do federally qualified HMOs, but they must meet the same requirements for a Medicare contract.

Policy Development

Implementation of PPS

FY 85 marked the second year of the Medicare prospective payment system (PPS). After successfully developing and implementing the major elements of the system, HCFA began updating the system in accordance with the provisions of the original PPS legislation. In addition, HCFA proposed refinements based on experience from the first year, as well as those mandated by the Congress in DEFRA.

Legislative Highlights

Several legislative provisions designed to improve health care access and delivery were enacted. Organ transplant legislation (Public Law 98-502) provided Federal Government funds to establish or expand organ procurement agencies and to establish a national system to aid in matching organ donors and recipients. Public Law 98-617 increased the Medicare hospice payment rate for routine home care in order to encourage greater hospice participation in the program. The Emergency Extension Act of 1985 (Public Law 99-107) extended the PPS rates and physicians' services payment rates that were in effect on September 30, 1985 until November 14, 1985.

Research, Demonstrations, and Evaluations

HCFA undertakes studies and demonstrations to develop ways to promote efficiency and quality in the Medicare and other HCFA programs. These assess the impact of the programs on health care costs, program expenditures, beneficiary access to services, health care providers, and the health care industry. These research and demonstration projects also test and evaluate alternatives to present reimbursement, coverage, eligibility, and management policies of the Medicare program.

HCFA conducted research, demonstration, and evaluation projects in the following program areas: hospital payment, physician payment, State programs for long-term care, alternative payment systems, program analysis and evaluation, coverage, and beneficiary awareness and prevention.

Validation Surveys of Hospitals Accredited by JCAH

The purpose of the Medicare validation program is to determine the effectiveness of the JCAH accreditation process in providing reasonable assurance that hospitals comply with the intent of the Medicare Conditions of Participation. Each year, a statistical sample of the approximately 5,100 JCAH-accredited hospitals is selected for validation surveys.

Under contract with the Secretary, State agencies (SAs) conducted 66 validation surveys during FY 85. HCFA's validation analysis was conducted in two areas: the Life

Safety Code (LSC) of the National Fire Protection Association and general health and safety requirements. During FY 85, 63 percent (42 of 66) of validated hospitals were in compliance with the LSC, and 80 percent (53 of 66) were in compliance with general health and safety conditions.

An accredited hospital is also subject to an SA survey where there is an allegation that significant deficiencies threaten the health and safety of patients. Allegation surveys evaluate only the specified condition(s), as authorized by HCFA's regional offices. If a significant deficiency is found in the specified condition(s), the investigation is expanded to a full survey. For this report period, 398 hospitals received allegation investigations. Of these, 11 percent (42 of 398) were found out of compliance with one or more conditions.

In both sample and allegation surveys, if significant deficiencies are found, the hospital is placed under SA surveillance until the deficiencies are corrected. The hospital is no longer deemed to meet Medicare Conditions of Participation, and the SA monitors the correction of any deficiency as if the hospital were unaccredited.

Medigap Voluntary Certification Program

HCFA continued to monitor the compliance of applicable State statutes and regulations with the minimum standards contained in the Federal Medigap law. These standards, developed by the National Association of Insurance Commissioners and incorporated into the Federal statute, are designed to provide minimum benefits and protections for individuals who wish to purchase private health insurance to supplement their Medicare coverage.

In addition, the Federal law provides criminal penalties for certain fraudulent or abusive marketing practices. HCFA screens complaints received from consumer organizations, individuals, and other government agencies and refers appropriate cases to the Office of the Inspector General or to State insurance departments for investigation and prosecution.

In FY 85, HCFA was informed of 17 possible violations of the penalty provisions. Of these, 4 are being investigated by specific State insurance departments and 13 were closed by HCFA due to lack of evidence.

CHAPTER 1. PROGRAM OPERATIONS

Beneficiaries

As of July 1, 1985, 28.2 million aged persons and 2.9 million disabled persons under 65, a total of 31.1 million, were entitled to coverage under Medicare. There were 30.6 million beneficiaries enrolled in the hospital insurance program (Part A) and 30 million enrolled in the supplementary medical insurance program (Part B).

Of beneficiaries age 65 and over, 95 percent were covered by both Part A and Part B, while 92 percent of all disabled beneficiaries were covered by both parts.

The number of aged persons entitled to Medicare increased over 600,000 (from 27.6 million to 28.2 million) over the July 1984 enrollment. The average age of beneficiaries also increased. The proportion of beneficiaries age 85 and over increased from 7 percent in 1970 to 10 percent in 1985. This factor, coupled with a significant increase in the intensity of services delivered, contributes to more extensive use of Medicare-covered health care services over a longer period of time.

Health Care Resources

As of July 1, 1985, there were 6,707 hospitals with 1,143,638 beds participating in Medicare, compared to 6,675 hospitals with 1,144,142 beds in FY 84. These include 6,034 short-stay hospitals, 474 psychiatric hospitals, and 199 other long-stay institutions.

As of July 1, 1985, there were 6,451 skilled nursing facilities (SNFs) participating in Medicare, up from 5,952 facilities as of July 1, 1984. Participating facilities include SNFs, separately organized extended-care units in hospitals, and some separate skilled nursing units connected with residential homes for the aged.

The number of home health agencies participating in the Medicare program rose from 4,684 to 5,679 in the 12-month period. A total of 3,980 independent laboratories had been approved for Medicare reimbursement, up from 3,801 the previous year. There were 428 rural health clinics, 72 comprehensive outpatient rehabilitation facilities, 336 ambulatory surgical centers, and 233 hospices certified to participate in the program.

As of July 1, 1985, under the renal disease program 1,393 facilities or units provided services to program beneficiaries requiring maintenance dialysis or kidney transplant.

Benefit Payments

In FY 85, the Medicare program paid $47.7 billion in benefits under Part A and $21.8 billion under Part B. These amounts represent an increase of 15 and 12 percent over the FY 84 payments of $41.5 billion and $19.5 billion, respectively.

Hospital Insurance

Inpatient Hospital Services
Hospitals were paid $44.8 billion in FY 85, which accounted for 94 percent of all Part A payments. Approximately 85 million inpatient hospital days were approved for payment. The aged accounted for 88 percent of the total, while the remaining 12 percent were for the disabled.

SNF Services
Part A of Medicare covers care in a skilled nursing facility after a beneficiary has been in a hospital for at least 3 consecutive days, and other conditions are met. Medicare paid $590 million for SNF services in FY 85, which is slightly over 1 percent of Part A payments. Of the 7.6 million days in SNFs approved for payment, 7.4 million were incurred by the aged and 0.3 million by the disabled.

Home Health Services
Part A home health benefit payments in 1985 totaled $2.26 billion, representing 4.6 percent of Part A payments. Over 39 million visits provided by home health agency personnel were approved for payment—36 million for the aged and 3 million for the disabled.

Hospices
A total of 14,874 persons received care in hospices in FY 85, with benefit payments totaling $15 million.

Supplementary Medical Insurance

Physician and Other Part B Suppliers' Services
Medical insurance payments for physicians and other Part B suppliers totaled $16.45 billion in FY 85. This includes $552 million for radiology and pathology services.

Other Medical Services and Supplies
In FY 85, the supplementary medical insurance program paid $4.0 billion for outpatient services, $663 million for group practice prepayment plans, and $658 million for independent laboratory services.

Program Funding

Under the Social Security Act, the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medicare Insurance Trust Fund are administered by two boards of trustees. Each is comprised of five members. Three members serve in an ex officio capacity: the Secretary of the Treasury, who is designated by law as the managing trustee of both funds; the Secretary of Labor; and the Secretary of Health and Human Services. Two public members are nominated by the President for a term of 4

years and confirmed by the Senate. The Administrator of the Health Care Financing Administration (HCFA) serves as secretary of both boards.

The primary source of Part A financing (92 percent) is contributions, based on earnings, by workers and their employers and by self-employed individuals. The remaining 8 percent is derived from general revenues for certain insured individuals who attained age 65 before 1975, premium payments for voluntarily enrolled individuals, transfers from the Railroad Retirement Board, military service credits, and interest on accumulated funds.

Part B is financed by three sources: premium payments from enrollees, contributions from general revenues, and interest on trust fund accumulation. The Part B premium under the Tax Equity and Fiscal Responsibility Act and the Deficit Reduction Act is set at 25 percent of program costs.

In FY 85, the Government contributed 73 percent of Part B program income; beneficiary contributions were 22 percent of program income. The remaining 5 percent of income resulted from interest accumulated by the trust fund. Some factors contributing to the rise in the cost of the Part B program are:

- Inflation of medical prices,
- Utilization of more expensive technology in health care delivery,
- Increasing rates of utilization of services, and
- Increases in both the number of aged beneficiaries and the proportion of persons age 75 and older within the aged population.

Additionally, coverage of the disabled became effective in July 1973 at the same premium rate as for beneficiaries over 65, even though medical care costs for the disabled are greater.

More detailed information about the status of the Hospital Insurance and Supplementary Medical Insurance Trust Funds, showing income, disbursement, and future projections, is contained in the annual reports submitted to the Congress by the boards of trustees of the two funds.

Claims Processing Performance

Intermediaries received 59.5 million claims in FY 85, an increase of 18.1 percent over the 50.4 million claims received in FY 84. Claims received by carriers rose at a rate of 18.3 percent, from 229.0 million in FY 84 to 270.8 million in FY 85. Overall, the volume of Medicare claims was 330.3 million, an 18.2 percent increase over the FY 84 figure of 279.4 million.

Distribution of Claims

The majority of claims received by intermediaries were requests for payment for outpatient services provided Medicare beneficiaries. These claims accounted for 62.8 per-

cent of intermediaries' claims. Inpatient hospital claims accounted for 20.0 percent of the receipts, while claims for HHA and SNF services represented 9.5 percent and 1.5 percent, respectively. The remaining 6.3 percent were claims submitted for ancillary and other miscellaneous services payable under Part B.

The distribution of claims received by carriers changed significantly from FY 84. The percent of claims submitted by physicians and suppliers on assignment increased from 55.9 to 67.6 percent. This increase was largely due to the inception of the Medicare Participating Physician/Supplier Program. In contrast, the percent of claims submitted unassigned by beneficiaries dropped from 43.3 to 32.3 percent, while those submitted by provider-based physicians and group practice prepayment plans fell from 0.9 to 0.1 percent.

Claims Processing Timeliness

When compared to the FY 84 experience, timeliness measures of contractor claims processing performance indicated an overall decline for both intermediaries and carriers.

The average processing time for intermediaries increased from 8.4 days to 12.4 days, and the average monthly percentage of bills pending over 30 days increased from 15.0 percent to 23.9 percent. (See Table 1.) There were several reasons for this deterioration: development of Medicare Secondary Payer (MSP) bills, consolidation of several contractor operations, new bill-processing systems at several contractors, changes in the method of reimbursement for independent laboratory services, and larger-than-anticipated increases in claims volumes.

Table 1. Claims Processing Timeliness for Intermediaries

Quarter	Contractor Processing Time (Mean Days) FY 84	FY 85	Percent of Claims Pending Over 30 Days FY 84	FY 85
1	7.3	9.9	15.8	18.8
2	8.3	14.8	14.5	21.2
3	8.4	N/A	14.4	25.9
4	8.7	N/A	15.2	29.7
Yearly Average	8.4	12.4*	15.0	23.9

N/A - Not available
*Based on first two quarters of FY 85.

Carriers showed an increase in yearly average claims processing time from 11.5 days to 14.9 days. Over the same time period, the average monthly percentage of claims pending over 30 days increased from 12.1 percent to 15.3 percent. (See Table 2.) As was the case for intermediaries, there were several reasons for the decline: development of MSP claims, implementation of HCFA Common Procedure Codes (i.e., changes in coding requirements), new claims-processing systems at several contractors, changes in the method of reimbursement for independent laboratory services, and larger-than-anticipated increases in bill volumes.

Table 2. Claims Processing Timeliness for Carriers

Quarter	Contractor Processing Time (Mean Days) FY 84	FY 85	Percent of Claims Pending Over 30 Days FY 84	FY 85
1	9.9	13.3	11.4	15.3
2	12.1	15.3	11.8	15.1
3	11.0	14.6	11.9	14.7
4	12.9	16.3	13.1	16.0
Yearly Average	11.5	14.9	12.1	15.3

Claims Pending

Both intermediaries and carriers experienced significant increases in the volume of pending claims. Pending claims rose 85.6 percent (from 1.11 million to 2.06 million) for intermediaries and 42.8 percent (from 7.73 million to 11.04 million) for carriers from the end of FY 84.

Contractor Administrative Costs

Intermediaries

For FY 85, intermediary administrative costs increased 13.7 percent to $336,298,361 as a result of a 17.1 percent increase in workload and increased emphasis on payment safeguard functions (audit, medical/utilization review, MSP). The bill-processing unit cost dropped from $2.64 to $2.33 as a result of increased efficiencies and productivity. Table 3 summarizes intermediary administrative cost experience in FY 84 and 85.

Table 3. Intermediary Administrative Costs

	FY 84	FY 85	Net Change	Percent Change
Workload Processed	$ 50,215,984	$ 58,814,147	$ 8,598,163	17.1
Total Cost	$295,691,780	$336,298,361	$40,606,581	13.7
Total Unit Cost	$ 5.89	$ 5.72	$ (.17)	(2.9)
Bill Processing Unit Cost	$ 2.64	$ 2.33	$ (.31)	(11.7)

Carriers

Carrier administrative costs increased by 16.2 percent to $599,188,551 as a result of an 18.4 percent increase in workload and increased emphasis on payment safeguard functions (medical/utilization review, MSP, physican fee freeze). The claims processing unit cost dropped from $2.04 to $1.88 as a result of increased economies of scale and greater efficiencies. Table 4 summarizes carrier administrative cost experience in FY 84 and 85.

Table 4. Carrier Administrative Costs

	FY 84	FY 85	Net Change	Percent Change
Workload Processed	$224,676,923	$265,936,345	$41,529,244	18.4
Total Cost	$515,833,214	$599,188,551	$83,355,337	16.2
Total Unit Cost	$ 2.30	$ 2.25	$ (.05)	(2.2)
Bill Processing Unit Cost	$ 2.04	$ 1.88	$ (.16)	(7.8)

CHAPTER 2. PROGRAM ADMINISTRATION

Quality and Appropriateness of Care

A major goal of the Medicare program is to assure that beneficiaries receive appropriate health care services. This is accomplished by requiring facilities that care for Medicare beneficiaries to be structurally safe, clean, properly staffed, and to provide needed services; the actual care delivered to beneficiaries must meet accepted professional standards. The Health Care Financing Administration (HCFA) must also make sure that services are necessary and are performed at the most economical level consistent with good care. These efforts ensure a high quality of care for beneficiaries while simultaneously constraining health care costs.

State Certification

In accordance with the Social Security Act, any facility providing health care services to Medicare beneficiaries must meet certain health and safety standards before it is eligible to receive reimbursement from Medicare. In order to ensure that these standards are met, HCFA provides for a periodic survey of each facility. These surveys are conducted by each of the States under contract with the Department. Because hospitals that are accredited by the privately run Joint Commission on Accreditation of Hospitals (JCAH) and American Osteopathic Association (AOA) are deemed to meet Medicare requirements, States survey only those hospitals not accredited by JCAH or AOA. On a sample basis, however, States conduct surveys of JCAH and AOA hospitals in order to validate that they continue to meet Medicare requirements. (For a complete report on the validation process, see Chapter 6 of this report.)

During FY 85, a new outcome-oriented survey process was developed and readied for implementation. Called the Patient Care and Services survey process, it was a major change in the conduct of surveys in nursing homes. Surveyors are now directed to focus more closely on the interview and observation of residents and less on paper review.

New, aggressive termination procedures were developed. A termination work group, consisting of representatives from the industry, States, and consumer groups, was convened. As a result, the new instructions, significantly clearer and tougher in terms of enforcement, were implemented without major problems.

Peer Review Organizations

Congress created the utilization and quality control peer review organization (PRO) program to replace professional standards review organizations (PSROs) in order to redirect, simplify, and enhance the cost-effectiveness and efficiency of the peer review process. Congress also wanted to make the program outcome-oriented with measurable objectives, as opposed to the emphasis in the PSRO program on the process of review.

PROs are physician groups authorized by statute to review Medicare services provided by hospitals, physicians, and other practitioners regardless of the setting in which they are provided. PROs are currently responsible, under the terms of their contract with HCFA, for medical review of all inpatient hospital care (whether acute or specialty) provided to Medicare beneficiaries. PROs have stringent quality review requirements and set objectives to be met. These objectives, which must demonstrate impact, range from reducing the risk of mortality to reducing avoidable postoperative infections. States may also contract with PROs to perform medical review for the Medicaid program. Finally, PROs perform reviews for private organizations.

For Medicare the statute requires that PROs address whether care is medically necessary, is delivered in the appropriate setting (e.g., whether it is necessary for the patient to be in the hospital), and meets professionally recognized standards of quality. For prospective payment system (PPS) hospitals, the statute requires PROs to conduct reviews to assure that admissions are necessary and appropriate, that diagnosis-related groups (DRGs) are accurately coded, and that day outliers are appropriate.

By November 1984, contracts had been negotiated, and 54 PROs (one in each State, the District of Columbia, Puerto Rico, the Virgin Islands, and the Pacific Territories) were designated and operating.

PRO contracts are awarded on a biennial basis, and current contracts expire in 1986. Program expenditures for this contract period are set at $322.4 million (apportioned). PRO review was completed for 3,568,484 Medicare discharges during FY 85.

HCFA is also continuing its efforts to assure that Medicare payment is made only for items and services which are medically necessary and of acceptable professional quality. HCFA continues to identify individual items, services, and procedures which are of questionable value. When HCFA obtains medical evidence that an item, service, or procedure is not safe and effective or that it is experimental, it discontinues payment for it. HCFA conducts these activities with the support of the Public Health Service and in cooperation with national medical and medical specialty societies.

Second Surgical Opinion Program

HCFA continued its major information campaign to encourage consumers to seek a second opinion before undergoing non-emergency surgery. The campaign was particularly directed to Medicare and Medicaid beneficiaries. HCFA's second surgical opinion program centers around two major efforts:

- A national second-opinion referral system, and
- A public information campaign.

In FY 85, nearly 10.5 million brochures entitled "Thinking of Having Surgery? Think About Getting a Second Opinion" were distributed to welfare offices, Social Security Administration district offices, consumer and professional groups, and individuals throughout the United States. Public service announcements promoting the second

opinion program and publicizing the national toll-free number (800-638-6833) were distributed to 730 television stations and over 6,000 radio stations.

Patients wishing second opinions can contact local referral centers or call the national toll-free number to obtain the name and telephone number of their local referral center.

Operational Reviews

Operational reviews assess the need for policy and operational reforms in vulnerable program areas. In order to provide HCFA senior management with financial and operational implications of their policy and management decisions, HCFA staff perform studies of selected program and policy issues through extensive research of in-house information supplemented by additional documentation and onsite review. FY 85 operational reviews are discussed below.

PRO/FI Denial/Adjustment Survey

A survey was conducted as Phase I of a more comprehensive review to assess the entire peer review organization/fiscal intermediary (FI) denial/adjustment process from PROs to FIs to carriers. The survey was necessary to determine the extent to which FIs were actually processing PRO denials/adjustments in accordance with HCFA directives regarding the automated model system. As a result of the study, HCFA identified implementation problems with processing of adjustments and was able to mobilize a coordinated approach to correct these problems.

Physician Fee Freeze Monitoring

A review was initiated to determine if carriers were correctly following HCFA instructions for monitoring nonparticipating physician adherence to the fee freeze. The review was conducted at seven carrier sites which serviced 26.2 percent of all nonparticipating physicians.

The review identified significant problems in the initial identification of potential fee-freeze violators as well as with ongoing carrier monitoring procedures. Additionally, HCFA instructions were unclear about which service dates should be used in monitored quarters.

To correct these problems, the regional offices were instructed to ensure that corrective actions are taken at the carriers found by the study to be deficient. In addition, revised manual instructions were prepared to clarify the dates of service to be included in a monitored quarter.

Provider-Based Physicians

In FY 85, HCFA conducted a comprehensive national study of the impact of new rules affecting coverage and reimbursement of the services of provider-based physicians. The new rules incorporated a number of changes, including those prescribed in TEFRA and a 40 percent limit on the reimbursement for inpatient radiology services.

The study revealed that the new 40 percent radiology payment limit appeared reasonable, and there were very few problems with implementation and compliance with the new rules. However, it was difficult to isolate the impact of the new rules on program expenditures because of other activities that coincided with their implementation.

Cardiac Rehabilitation Program

A review involving 62 fiscal intermediaries and 537 providers was conducted primarily to identify the cost to Medicare of the Cardiac Rehabilitation Program (CRP). The review collected information on which providers had cardiac rehabilitation (CR) units; the type, number, and cost of CR service by facility; and the FIs' procedures for monitoring CRP activities. The review found that:

- The FIs could not readily identify providers with CR units.
- Hospitals were not familiar with HCFA's coverage and reimbursement policies relating to the CRP.
- Approximately 64 percent of all CR services being billed to the program are for noncovered services.

As a result of the review, new instructions are being prepared that will provide fiscal intermediaries with a better methodology for identifying and monitoring the CRP and related services.

National Cardiac Pacemaker Study

This review compared the time, complexity, and payments made to physicians on pacemaker operations in 1966-67 with pacemaker operations performed in 1984. The review examined medical records on more than 2,000 pacemaker operations at over 100 randomly selected hospitals. The review found that the physician time needed to implant a pacemaker had been cut by 30 percent during the 18-year period, but payment to physicians has kept pace with inflation in other physician services.

The results of this review will be used in a report to Congress on pacemakers mandated by the Deficit Reduction Act of 1984 (DEFRA).

Intermediary and Carrier Performance

Within general guidelines issued by HCFA, intermediaries and carriers must develop effective administrative mechanisms for achieving required program results. This has led to different patterns in the internal administration and operation of the intermediaries and carriers. Much of the success of Medicare, particularly its acceptance by the health community, is attributable to the opportunities presented by such an administrative pattern. Intermediaries and carriers can develop uniquely responsive mechanisms to meet the variable patterns in the nation's health care system.

Beneficiaries and the health community, as well as the public at large, judge the performance of Medicare largely by the performance of intermediaries and carriers. Contractors' effectiveness in processing claims, in communicating program policies and procedures to the public, and in establishing relationships with the health community, shapes the public and professional response to the program.

Contractor Performance Evaluation Program

HCFA evaluated the performance of Medicare contractors by using the Contractor Performance Evaluation Program (CPEP). The CPEP is comprised of pre-established performance criteria and standards with specific acceptance quality levels for each area of performance measured. The CPEP is divided into two parts: the Part A CPEP is applicable to intermediaries, which deal primarily with the hospital insurance portion of Medicare; the Part B CPEP is applicable to carriers, which deal with the supplementary medical insurance portion of Medicare. The criteria and standards are applied to the contractors as uniformly as possible. Each fiscal year the criteria and standards are revised and refined to more accurately measure contractor performance.

The CPEP is implemented by HCFA's 10 regional offices. Throughout the fiscal year, the regional staffs evaluate contractor performance by conducting onsite reviews and analyzing performance data as required in the CPEP. At the end of the year, each region prepares and publishes Annual Contractor Evaluation Reports for each contractor in its service area.

HCFA uses the results of the application of CPEP criteria and standards as the major factor in contract management. When combined with historical perspective, the CPEP has proved to be an effective tool for identifying those contractors exhibiting a pattern of continuous deficient or excellent performance. Establishing performance goals and monitoring and evaluating systems have achieved overall improvement in contractors' operations.

In FY 85, the Part A CPEP measured performance in the following major areas: bill processing, provider reimbursement, contract management, productivity investments, payment safeguards, and beneficiary and provider service. The Part A statistical standards measured unit cost and timeliness of bill processing.

Major areas covered by the Part B CPEP in FY 85 included claims processing, productivity investments, payment safeguards, beneficiary services, and contract management. The Part B statistical standards were unit cost of claims processing, timeliness of claims processing, and quality of claims processing.

The CPEP was essentially carried over from the previous year's version to accommodate significant changes in legislative priorities. Elements and criteria were reordered to align with budget line items. This allows contractors to prepare budgets according to the performance expectations in the CPEP.

Quality Control Programs

HCFA monitors the quality of Medicare program administration through an array of payment review and other programs.

Part A Quality Assurance Programs

Hospital and Home Health Agency Reimbursement Review
The Hospital Reimbursement Review Program (HOSP-RRP) and the Home Health Agency Reimbursement Review Program (HHA-RRP) are comprehensive programs designed to evaluate the quality of the settlement of provider cost reports by Medicare intermediaries. Scores are fed into the CPEP as the only evaluative measure under intermediary audit and reimbursement functions.

HCFA's 10 regional offices perform the reviews, with central office assistance when necessary. The reviews are performed on a sample of provider cost reports that were settled within certain designated periods. The programs consist of a series of procedures to evaluate significant areas of provider cost reimbursement.

In FY 85, 57 intermediaries were evaluated under the HOSP-RRP and 49 intermediaries were evaluated under the HHA-RRP. A total of 98 hospital providers and 93 HHA providers were reviewed. Total estimated dollar recoveries were $2.1 million.

Quality Evaluation of Settlement under TEFRA
The Quality Evaluation of Settlement under TEFRA (QUEST) program is designed to measure the intermediaries' performance in reviewing, auditing, adjusting, and settling hospital cost reports under TEFRA.

The program also:

- Determines adherence to Medicare reimbursement policies, procedures, and regulations;
- Determines adequacy of TEFRA base-year calculations;
- Identifies problems in Medicare policy;
- Identifies overpayments, where applicable; and
- Is the basis for measuring the CPEP element for TEFRA hospital cost report settlement quality.

In FY 85, 59 intermediaries were evaluated under QUEST. The total number of hospital providers reviewed was 277, and total estimated dollar recoveries were $1.6 million.

Home Office Quality Evaluation of Settlements under TEFRA
The objective of the Home Office Quality Evaluation of Settlements under TEFRA (HO-QUEST) is to provide the regional office reviewer with a uniform guide to evaluate the quality of intermediary performance in home office audits.

In FY 85, regional office personnel completed 30 HO-QUEST reviews and central office personnel completed 5. As a result of HO-QUEST reviews, program overpayments identified totaled $1.1 million.

PPS Interim Payment Review Program
The PPS Interim Payment Review Program is designed to monitor intermediaries' performance in calculating and adjusting the PPS interim rates for hospitals. The evaluation of the intermediaries' performance is accomplished through a review of PPS interim rate calculations made during the period of September 1, 1984, to August 31, 1985.

A sample of 478 hospitals was reviewed to verify the computation of interim rate reimbursement for the following items:

- Part A inpatient operating costs,
- Capital-related costs,
- Direct medical education costs,
- Kidney acquisition costs,
- Medicare-allowable bad debts,
- Return on equity capital for proprietary providers, and
- Indirect cost of medical education.

The reviews identified erroneous interim payment amounts of approximately $47.9 million ($33.3 million in erroneous interim overpayments to providers and $14.6 million in erroneous underpayments). The consequence of the erroneous overpayments is that the Hospital Insurance Trust Fund loses interest on these amounts during the hospital's fiscal year. The money is recovered at the end of each hospital's fiscal year when settlement is made on the basis of a submitted cost report.

PPS Bill Payment Review Program
The PPS Bill Payment Review Program is designed to monitor intermediaries' performance in calculating payment amounts for Medicare PPS bills. The evaluation of the intermediaries' performance was accomplished through a review of payment calculations for 1,959 bills processed during the period of October 1, 1984, to August 31, 1985. The samples were selected by the regional offices responsible for performing the reviews. Reviews identified $27,870 in program overpayments and $5,305 in program underpayments.

Part B Quality Assurance Program

The Part B Quality Assurance program was designed to provide a statistically valid and objective procedure for evaluating carrier claims processing performance. A national quarterly report is published which ranks carriers based on the cumulative error rates assessed during the most recent 12-month period. Carriers are ranked both on occurrence error rate (processing errors per 100 line items in the universe) and on payment/deductible error rate (dollar errors per 100 dollars of submitted charges in the universe). A penalty figure is included in the payment/deductible error rate when a carrier fails to review all sample claims selected.

Results were as follows:

- Thirty-three Medicare Part B carriers (46 processing sites) processed 256 million claims with submitted charges totaling $34 billion. Normally, 38 carriers (53 processing sites) operate Medicare Part B, but not all submitted data on time.
- Carrier occurrence error rates ranged from 0.8 to 21.4. The mean occurrence error rate was 6.7.
- Carrier payment/deductible error rates ranged from 0.3 to 3.8. The mean payment/deductible error rate was 1.8.
- Payment/deductible dollar errors, representing overpayments and underpayments and misapplication of the deductible, plus penalty totaled $601 million. The mean number of payment/deductible dollar errors was $13.0 million.

The total payment/deductible error rate and the mean carrier error rate remained constant with the preceding year at 1.8 percent. The FY 85 national overpayment error rate, based on 46 of 53 carrier locations reporting, was 0.9. This indicates that $0.90 was estimated to be overpaid per $100 of submitted charges. For FY 84, this error was 1.0.

Waiver-State Audits and Overviews

Base-year audits to set PPS rates were performed in the waiver States – Maryland, Massachusetts, New Jersey, and New York. The results of the overviews in Massachusetts, New Jersey, and New York disclosed no major problems. Because audits had not been performed in Maryland since 1977, the audit effort was directed to more complex auditing techniques. The national audit program was adapted for the Maryland audits, which audits were performed by two Blue Cross plans and three CPA firms.

Other Performance-Improvement Initiatives

Improvements in Billing

Automated Billing

HCFA's efforts to increase the volume of electronic media claims (EMC) submitted to intermediaries and carriers have increased significantly since July 1982 when nation-

al and regional EMC goals were established. The EMC goals were established by individual contractors as a percentage of the total volume of claims that they were expected to receive electronically. The overall EMC effort was successful, as demonstrated by the fact that the FY 85 national Part A EMC goal of 50 percent was exceeded (57.2 percent) and the Part B EMC goal of 20 percent was surpassed (24 percent).

Provider Uniform Billing
HCFA implemented nationwide the HCFA-1450 uniform bill for all inpatient and outpatient Medicare institutional-provider billings. This was the culmination of an effort that began during FY 83. A standard electronic billing specification using the UB82 data set has also been developed and published and may be implemented in lieu of the paper form.

Centralization of Direct Billing and Collection
During preceding years the Social Security Administration (SSA) printed and mailed bills from its Baltimore headquarters to 825,000 Medicare beneficiaries who are billed directly for their Medicare premiums. These punchcard bills and premium payments were then returned to eight different SSA Program Service Centers for processing.

In FY 85, the punchcard operation was converted to a centralized lockbox operation, where all premiums are paid and processed by a private bank. Beneficiaries are provided a portion of the new bill as a receipt. The bill is easily readable and is processed using automated equipment. Beneficiaries now receive the bills at least 5 days earlier, and all funds collected by the lockbox bank are deposited to the Treasury Department within 72 hours. The conversion of the operation to a lockbox bank resulted in yearly savings of about $1,550,000.

Beneficiary Service Improvements at Contractors
During FY 85, Medicare carriers handled 16,375,462 beneficiary inquiries (12,117,654 telephone, 3,747,921 written, 509,887 walk-in). This represented a 25.2 percent increase over FY 84. In the same period, Medicare intermediaries handled 1,301,804 beneficiary inquiries (933,818 telephone, 305,460 written, 62,526 walk-in), an 18.4 percent increase over FY 84.

Medicare carrier procedures and standards were released on improvements to beneficiary services. These instructions and standards require carriers to:

- Provide toll-free and local telephone service for beneficiary inquiries.
- Establish and maintain a minimum busy-signal standard.
- Maintain specific standards for handling written and walk-in inquiries.
- Meet standards for accuracy and timeliness of responses to beneficiaries.

Physician Fee Freeze and Participating Physician Program

For 15 months beginning July 1, 1984, Medicare customary and prevailing charges for physician services were frozen at the levels that were in effect for the 12-month period ending June 30, 1984. In addition, during the period of the freeze, nonparticipating physicians were not permitted to increase their actual billed charges to Medicare patients. Participating physicians were allowed normal increases in their actual charges to Medicare patients during the freeze period. These normal increases will be recognized in future calculations of customary charges of participating physicians.

A participating physician is one who voluntarily signs an agreement to accept assignment for all services provided to Medicare patients during the following 12-month period. Nonparticipating physicians are allowed to accept assignment on a claim-by-claim basis. Increases in actual charges of nonparticipating physicians will not be recognized in future customary-charge screen calculations.

Incentives for physician participation include directories of participating physicians, dissemination of names of participating physicians via toll-free telephone lines, and provision for electronic receipt of claims by carriers.

To determine whether nonparticipating physicians did not charge more than their charge for the base period (April through June 1984) each carrier does a quarterly monitoring of claims processed during that review quarter with service dates after September 30, 1984. The 10 top procedures and 10 random procedures are reviewed for each nonparticipating physician.

For FY 85, 119,525 agreements from physicians were received, representing 138,179 individuals. This represented 30 percent of physicians billing Medicare. (Since many hospital groups and other groups participated but sent in one agreement for the whole group, the number of individuals is greater than the number of agreements.) Suppliers were represented by 17,822 agreements or 23.8 percent of the total.

Reasonable Cost Limits for Home Health Agencies

Legal limits on home health agency costs were revised, effective July 1, 1984, continuing the methodology in the previous schedule and incorporating changes in inflation estimates and metropolitan statistical area designations. The schedule expanded the adjustments for prevailing wage levels from wages to all labor-related costs. It also provided for the exclusion of extremely high and low costs from those used to establish the limits.

The revision of the limits, effective July 1, 1985, incorporated the first major revision in methodology since the original limits were promulgated. The changes in this schedule of limits included a more accurate method of identifying and excluding extremely high and low costs from those used to establish the limits. The limits were es-

tablished at a percentage of mean cost, rather than the percentile method previously used. With the availability of accurate data from the uniform method of cost finding, these limits apply to the per visit cost of each discipline, rather than the aggregate cost of all disciplines. During FY 85, the limits were set at 120 percent of mean cost.

Payment for Clinical Diagnostic Laboratory Tests

HCFA published reimbursement guidelines that implement the provisions of section 2303 of DEFRA. For services rendered July 1, 1984, or later, the instructions require establishment and use of fee schedules on a carrierwide basis (not to exceed a statewide basis) for payment of clinical diagnostic laboratory tests performed in a physician's office, by an independent laboratory, or by a hospital for its outpatients. The fee schedule amounts are set at 60 percent of the prevailing charges for laboratory tests performed in physicians' offices and by independent laboratories. For hospital outpatient laboratory tests, the fee schedule amount is established at 62 percent of prevailing charges.

Reimbursement for Durable Medical Equipment

New rent/purchase procedural guidelines for durable medical equipment (DME) were published in December 1984 with a February 1, 1985, effective date. The instructions limit rental payments for equipment costing under $120 to the reasonable purchase price and require carriers to determine whether rental or purchase is more economical for the Medicare program for DME over $120. If purchase is found to be more economical, subsequent rental payments are limited to the reasonable purchase price. The objective is to eliminate excessive payments associated with long-term rentals when purchase is more appropriate.

Medicare Secondary Payer Program

In FY 85, the Medicare Secondary Payer (MSP) program was fully implemented, with expanded operations for both the working aged and automobile no-fault and liability provisions. In FY 85, MSP saved the Medicare Trust Funds $750 million. With a budget of $27 million, the cost benefit ratio was $1:$28. This cost-containment program is unique in that it causes no additional outlay of moneys by the beneficiaries or reduction in revenue to providers of medical services.

HCFA issued policy and procedural instructions for implementing section 2344 of DEFRA, which made more explicit than prior law the Federal Government's subrogation rights to recover Medicare benefits directly from responsible automobile and liability insurance companies, employer group-health plans, and workers' compensation carriers. The law also gave the Government the right to recover its benefits from any individual or entity that receives a payment from any of those insurers or plans.

Improving Utilization Safeguards

One of the most critical areas of Medicare program activity is to establish safeguards against improper and excessive utilization of health care services. HCFA continued to refine the prepayment screens which carriers utilize to identify situations of potential overutilization or variations from medical necessity norms. HCFA implemented

nationwide screening parameters for procedures and pilot tested others in 22 carriers for possible implementation in FY 86. Under those screens, when a claim represents services exceeding the HCFA set parameters, the carrier must review to assure it is a claim for medically necessary services.

A particularly important screen, utilized by many Part B carriers, permits the prompt identification of individual physicians whose total bills for Medicare patients in given periods significantly exceed what would normally be expected in ordinary practice.

Prepaid Health Plans

During FY 85, HCFA continued its emphasis on enrolling Medicare beneficiaries in prepaid health plans such as health maintenance organizations (HMOs) and competitive medical plans (CMPs). Such plans are continuing to increase in number as an alternative to traditional forms of health care delivery. Generally, a prepaid plan is an organization which provides its members comprehensive health services, without regard to frequency or extent of services, in return for a predetermined, fixed premium paid by its members.

Because members pay a fixed amount for care, there is great incentive for HMOs to reduce the cost of care. They strive to reduce costs by emphasizing preventive care and health education, by providing only medically necessary care, and by using ambulatory care rather than more expensive inpatient hospital and other institutional care whenever possible.

The Federal Government benefits by having medical care delivered through an efficient health care delivery system. Competition among plans, as well as competition between the traditional providers and these plans, leads to increased benefits for beneficiaries. HCFA believes this availability of choice for health care leads to more cost conscious and informed beneficiaries.

Provisions of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) that took effect in 1985 gave competitive medical plans the status of organizations eligible to enter into Medicare contracts. CMPs have more flexibility than federally qualified HMOs in terms of benefit design and organizational structure. However, they must meet the same requirements for a Medicare contract as HMOs.

Increased Enrollment of Beneficiaries

The passage of TEFRA enhanced HCFA's capability to enroll members in prepaid plans. During FY 85, HCFA continued its emphasis on beneficiary enrollment in HMOs. In April 1985, 32 demonstration contracts with 300,000 enrollees were converted to TEFRA risk contracts. By the end of FY 85 there were a total of 67 TEFRA risk contracts, and enrollment had grown to 364,397. Payments for benefits under TEFRA risk contracts totaled $415 million.

Payments to HMOs and CMPs

HMOs and CMPs are reimbursed by Medicare for services covered under both Part A and Part B. HMOs receive monthly capitation payments based on either cost or risk contracts.

TEFRA significantly altered Medicare risk contracting when it took effect in February 1985. The old risk contract option was replaced by prospective reimbursement under risk-sharing contracts with HMOs and other eligible organizations at a rate equal to 95 percent of the adjusted average per capita cost (AAPCC). The AAPCC is an actuarial estimate made by HCFA in advance of an organization's contract period. The AAPCC represents what the average per capita cost to the Medicare program would be for each class of the organization's Medicare enrollees if they had received covered services through the regular Medicare program.

To the extent that Medicare's coverage payment is expected to exceed the eligible organization's adjusted community rate under a risk-sharing contract, the organization must either return the excess money to HCFA or use the savings to provide its Medicare members with additional benefits (selected by the organization and approved by the Secretary) or reduced cost-sharing. HMOs and CMPs with risk contracts receive fixed and periodic payments on behalf of enrollees, provide physician services through staff physicians or physicians under contract, assume financial risk on a prospective basis, and meet financial viability standards.

TEFRA and the implementing regulations formally established the principle of prepayment. HMOs can now enter into contracts with HCFA and receive fixed monthly payments in advance for each Medicare beneficiary that they enroll.

The law also formalized the lock-in concept. In most instances, if the beneficiary knowingly goes outside of this managed care delivery system to obtain health care, neither the plan nor the Government is responsible for any health care costs incurred by the beneficiary.

The TEFRA regulations articulated to the industry that certain requirements had to be met before a plan qualifies for a TEFRA contract:

- The plan must be a federally qualified HMO/CMP as determined by the Office of Health Maintenance Organizations.
- No more than 50 percent of the plan's membership can be Medicare/Medicaid and the plan has to have at least 5,000 commercial members.

CHAPTER 3. POLICY DEVELOPMENT

Implementation of PPS

FY 85 marked the second year of the Medicare prospective payment system (PPS). Under PPS, each hospital is paid a predetermined, fixed rate for each Medicare inpatient discharge in accordance with a payment schedule for standard types of discharges. Each discharge is classified into one of 468 diagnosis-related groups (DRGs). Assignment to a DRG is based on the patient's principal diagnosis, the presence of comorbid or complicating conditions, procedures performed, and the patient's age, sex, and discharge status.

After sucessfully developing and implementing the major elements of the system, the Health Care Financing Administration (HCFA) began updating the system in accordance with the provisions of the original PPS regulations. In addition, HCFA proposed refinements based on experience from the first year, as well as those mandated by Congress in the Deficit Reduction Act of 1984.

Provisions of HCFA's final regulations for FY 85 are discussed below.

Rural Referral Centers

HCFA provided additional criteria to enable rural hospitals with less than 500 beds to qualify as referral centers. Thus, in addition to the criteria published on January 3, 1984, effective with cost reporting periods beginning on or after October 1, 1984, a rural hospital can qualify as a rural referral center if it is larger than the average rural hospital, treats a relatively more complex mix of cases than other rural hospitals, and meets criteria relating to specialty composition of medical staff, source of inpatients, or volume of referrals.

The regulations provide that all rural hospitals qualifying as referral centers will be paid on the basis of the urban standardized amount adjusted by the hospital's area wage index effective with the hospital's cost reporting period beginning on or after October 1, 1984.

Other Rule Changes

In addition to these changes, other payment provisions under PPS were modified in the final rule. These included:

- Adjusting the rural standardized amounts for hospitals located in areas that are designated as rural after April 20, 1983;
- Clarifying to which census division a hospital belongs when a metropolitan statistical area or New England County Metropolitan Area in which the hospital is located crosses a census division boundary;

- Providing day outlier payments for transfer cases; and
- Under certain circumstances, providing additional payments to a hospital for inpatient renal dialysis.

Exclusions from PPS

The statute excludes several types of hospitals and hospital units from PPS. These include psychiatric, long-term care, children's, and rehabilitation hospitals as well as psychiatric and rehabilitation units operating as distinct parts of acute- care hospitals. As of the end of FY 85, 481 psychiatric hospitals, 68 rehabilitation hospitals, 86 long-term care hospitals, and 53 children's hospitals had been excluded from PPS. In addition, 733 psychiatric units and 386 rehabilitation units had been identified for exclusion.

An additional temporary exclusion was authorized by regulation for both alcohol/drug specialty hospitals and alcohol/drug distinct-part units of acute-care hospitals. As of FY 85, 28 hospitals and 326 units had been temporarily excluded from PPS as alcohol/drug treatment facilities.

The statute also excludes from PPS hospitals located outside the 50 States and the District of Columbia. However, a study is being conducted to find a method for including such hospitals under PPS.

Facilities and units excluded from PPS continue to be paid on the basis of reasonable cost subject to the rate-of-increase ceiling. Under this ceiling, Medicare reimbursement for hospital inpatient operating costs per discharge is limited to a target percentage increase over the preceding period's costs.

In addition, hospitals in States which operate approved statewide reimbursement control systems may be paid under the State system rather than under PPS. Some 552 hospitals in four States – Massachusetts, Maryland, New Jersey, and New York – are paid under this authority. (However, Massachusetts and New York initiated plans to end State cost-control exclusions for their hospitals and to have those hospitals included under PPS effective October 1, 1985, and January 1, 1986, respectively.)

Veterans Administration hospitals and nonparticipating hospitals furnishing emergency services to Medicare beneficiaries regardless of their location are also excluded from PPS. Health maintenance organizations may elect to retain per capita payments for inpatient hospital services furnished to their enrollees or have Medicare pay the hospital directly under PPS.

Legislative Highlights

Table 1 contains a summary of legislative highlights for FY 85.

Table 1

MAJOR MEDICARE-RELATED PUBLIC LAWS

TITLE	PUBLIC LAW NUMBER	DATE OF ENACTMENT	MAJOR PROVISIONS
National Organ Transplant Act	P.L. 98-507	10/19/84	- Establishes a 25-member task force to study organ transplant issues - Authorizes grants for organ procurement organizations - Prohibits the buying and selling of human organs - Requires HHS to establish a register of organ donors and recipients
Amending part A of the Medicare program with respect to hospice payment rates for routine home care	P.L. 98-617	11/8/84	- For one year, establishes $53.17 as the daily payment rate for hospice routine home care and makes the rate retroactive to October 1, 1984 - Requires HHS to report to Congress annually on the review of the rates and on the adequacy of the rates - Makes several technical corrections to P.L. 98-369, the Deficit Reduction Act of 1984 (DEFRA)
Departments of Labor/HHS/ Education and Related Agencies Appropriations Act, 1985	P.L. 98-169	11/8/84	- Appropriates $18.75 billion for payments to the Medicare Trust Funds
Emergency Extension Act of 1985	P.L. 99-107	9/30/85	- Extends for 45 days the PPS rates and physicians' services payment rates in effect on September 30, 1985

OTHER LAWS WITH PROVISIONS IMPACTING ON MEDICARE

TITLE	PUBLIC LAW NUMBER	DATE OF ENACTMENT	MAJOR PROVISIONS
Making Continuing Appropriations for FY 85	P.L. 98-441	10/3/84	- Provided funding for HHS' programs from October 1 through October 11, 1984 at the rate of operation and under the terms and conditions provided in FY 84
Making Further Continuing Appropriations for FY 85	P.L. 98-455 P.L. 98-461	10/6/84 10/10/84	
Older Americans Act Amendments of 1984	P.L. 98-459	10/9/84	- Requires OAA area agencies on aging to focus on the needs of nursing home residents and establishes procedures for coordinating OAA programs with Medicare, Medicaid, and title XX (social services) programs - Requires the Commissioner on Aging to establish planning linkages with peer review organizations

Table 1 (continued)

TITLE	PUBLIC LAW NUMBER	DATE OF ENACTMENT	MAJOR PROVISIONS
Social Security Disability Benefits Reform Act	P.L. 98-460	10/9/84	- Temporarily reauthorizes (but makes permanent for SSI disability recipients) an expired provision of law permitting individuals notified of termination to elect to have disability benefits and Medicare coverage continued through the Administrative Law Judge level of appeal
Making Continuing Appropriations for FY 85	P.L. 98-473	10/12/84	- Temporarily provided funding for HHS' programs at the rates established in the Conference Report to H.R. 6028, the Labor/HHS/Education appropriations bill - Requires the Connecticut hospice to be reimbursed as under the HCFA hospice demonstration - Specifies that under the Indian Health Service Act, $10 million of the carryover balance in the Medicare/Medicaid fund be used to fund mandatory cost increases in the hospitals and clinics program
Alcohol, Drug Abuse, and Mental Health Amendments of 1984	P.L. 98-509	10/19/84	- Requires HHS to provide Congress with a plan to combat alcohol abuse and alcoholism which contains legislative recommendations to improve those relevant activities and services provided under titles XVIII and XIX of the Social Security Act
Department of Defense (DoD) Authorization Act	P.L. 98-525	10/19/84	- Authorizes HHS and DoD to study jointly the possible effects of the adoption by the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) of a prospective payment system for inpatient hospital services such as that utilized under Medicare. The study must also address the feasibility of statutorily linking provider participation in Medicare with provider participation in CHAMPUS.
Health Promotion and Disease Prevention Amendments of 1984	P.L. 98-551	10/30/84	- Expands the role of the National Center for Health Services Research (NCHSR) to include new medical technology assessment responsibilities and establishes two councils to assist in carrying out the new functions - Renames NCHSR the National Center for Health Services Research and Health Care Technology Assessment
Preventive Health Amendments of 1984	P.L. 98-555	10/30/84	- Reauthorizes through FY 87 provisions of the Public Health Service Act to provide $5 million a year for grants to meet the initial costs of establishing and operating home health programs. Reauthorizes $2 million a year over the same period for home health training programs

CHAPTER 4. RESEARCH, DEMONSTRATIONS, AND EVALUATIONS

Introduction

Research and demonstration activities carried out by the Health Care Financing Administration (HCFA) provide knowledge to enable the Administrator, the Secretary, the Congress, and other interested parties to make informed, rational decisions regarding HCFA programs and policies.

HCFA's research, demonstration, and evaluation activities include projects to test new reimbursement, coverage, eligibility, and program-management approaches as well as research and evaluation studies of the impact of HCFA programs on health care costs, program expenditures, beneficiary access to health care services, and the economics of the health care industry. HCFA is extensively involved in the creation of new and improved data sets to support these ongoing research and demonstration activities. These projects result in knowledge about the basic structure, incentives, costs, and effects of HCFA programs and policies and make it possible to refine existing policies, simulate or test various program changes on a trial basis, and develop innovative financing and delivery systems.

In addition to its intramural projects, HCFA spent almost $33 million in FY 85 for grants and contracts to conduct research, demonstration, and evaluation projects. The seven program areas were hospital payment, physician payment, State programs for long-term care, alternative payment systems, program analysis and evaluation, coverage, and beneficiary awareness and prevention.

Information on HCFA research and demonstration findings and projects can be obtained from the publications office identified at the end of this chapter. Of particular interest may be the Health Care Financing Status Report which describes each project. The April 1985 edition of *Research and Demonstrations in Health Care Financing* is available from the National Technical Information Service (accession number PB 85-234888/AS).

Hospital Payment

The Social Security Amendments of 1983 (Public Law 98-21) included a congressional mandate to study a number of issues relating to the prospective payment system (PPS), including its impact on health care delivery and financing systems and the expansion of PPS to hospitals not now subject to the system and to other third-party payers. Public Law 98-369, the Deficit Reduction Act of 1984 (DEFRA) added to the congressionally mandated studies. In addition, other types of acute care (and alternatives to hospital care, such as hospice care) are of major importance to the Medicare program in terms of cost-effectiveness and quality of care and services. During FY 85 work was begun on all of these studies.

Public Law 98-21 also requires the Secretary to report annually on the impact of PPS during the previous year on classes of hospitals, beneficiaries, other payers of inpatient hospital services, other providers, etc. This represented a major new effort for HCFA. Work was also begun on this report during FY 85.

HCFA continued to study State hospital payment system demonstrations (such as the Rochester Area Hospital Corporation demonstration) that differ from the Medicare PPS to determine their cost-effectiveness.

Intramural research work was extended into hospital malpractice insurance, disproportionate-share hospitals (low-income and Medicare patients), analysis of skilled nursing facility (SNF) patient classification groups, analyses of the indirect teaching adjustment formula, incorporation of capital-cost prospective payments, and alternative methods for recalibration of diagnosis-related group (DRG) weights. Analyses of the impact of PPS's proposed FY 1986 payments on types of hospitals were performed.

A series of projects was initiated for developing improved methods for assessing the quality of care provided to Medicare beneficiaries. External projects were being conducted by the Rand Corporation, the University of California at San Francisco, and the Commission for Hospital and Professional Activities.

A compendium of articles on refining case mix and severity of illness was published in the *Health Care Financing Review, 1984 Annual Supplement* in December 1984.

Physician Payment

Congress mandated that the Department study the feasibility of including in the hospital DRG amounts payment to physicians for services provided to hospital inpatients. In order to study the feasibility and desirability of such "bundling" of services, HCFA continued to develop a physician data base using survey data (such as the survey of physician practice costs and income), samples from carriers, and research data. These data bases will permit the reliable application of statistical methods for research and policy simulation and analysis.

A new Part B data base, BMAD, was begun that can be used to examine a number of potential refinements. These data from carriers provide details on services given to beneficiaries by physicians and other suppliers.

A survey of physicians' costs and incomes was completed. Data from earlier physician surveys were used to update and refine the Medicare Economic Index. Data from this survey enhanced HCFA's ability to assess the impact of various physician reimbursement alternatives.

State Programs for Long-Term Care

In response to the increasing demands being made on the long-term care delivery and financing system, and to the move away from the traditional institutional approach toward caring for the needs of the elderly in the community, HCFA and the States are interested in taking actions aimed at furthering a mutual understanding of the long-term care population and developing alternatives to existing reimbursement and delivery systems.

In general, HCFA's long-term care *research* activities involve the use and analysis of existing data, either collected by survey or abstracted from other data sources. During FY 1985, long-term care research focused primarily on describing and explaining the demand for long-term care and the basic economic underpinnings of the long-term care industry. In addition, considerable effort was given to the development of a methodology to measure the quality of long-term care provided in different settings. This research was developed to provide an understanding of long- term health care delivery, reimbursement, and financing systems in order to provide some direction for private and public policymaking and to identify promising areas for demonstration activities.

HCFA's long-term care *demonstrations* require the development of a rigorous research design. Within the design, a specific intervention is introduced into a live situation and the outcomes are observed. The evaluation findings, based on these observed outcomes, form the basis for future policy recommendations.

HCFA continued to develop data and information bases that provide a deeper understanding of the aged population and its social (family, community, financial) setting and that permit analysis, and policy and research simulation. HCFA worked with States to identify, develop, demonstrate, and evaluate cost-effective alternative payment and delivery systems for long-term care that ensure beneficiaries' continued access to quality health care. The agency also continued previously initiated evaluations of demonstrations, including the evaluation of the long-term care channeling demonstrations.

Alternative Payment

Prior research and demonstration activities related to alternative payment focused primarily on health maintenance organizations (HMOs). This work determined that alternative delivery systems and alternative risk- reimbursement mechanisms are cost effective and offer Medicare beneficiaries the opportunity for improved benefits over the existing fee-for-service system. With the implementation of the HMO provisions of the Tax Equity and Financial Responsibility Act (TEFRA), there was a need to go beyond HMO and competitive medical plan (CMP) designs and test other delivery and financing systems that enhance competition among providers and yield potential savings in the program.

Within this area, HCFA attempts to identify, test, and evaluate cost-effective alternative delivery and/or financing systems that affect multiple segments of the program. Efforts therefore focused on projects designed to test systems that capitate payments for various types of services, and projects that tried to refine or test alternatives to the current methods and bases for payment to capitated systems.

Since 1980, HCFA has supported several demonstrations that have tested alternative, innovative reimbursement methods. These include:

- The social health maintenance organization concept, a capitated delivery/financing system that integrates health and social services under the direct management of the provider of services.
- Competitive models for clinical laboratory services and durable medical equipment, started as an alternative to the current financing system.

HCFA continued several other demonstrations in this area that were begun in previous years. Projects under which vouchers are provided directly to Medicare and/or Medicaid beneficiaries in a specific geographic area for the purchase of health benefits were in the early planning stages.

HCFA began work on possible adjustments to the AAPCC, to determine whether it needs to be refined. Factors under study include prior use as a proxy of health status, former entitlement to Social Security disability, hospital diagnosis, functional status, and self-reported measures of health.

Program Analysis and Evaluation

HCFA studied several aspects of program performance in order to gain a better understanding of the factors influencing utilization of particular types of services, of the characteristics of certain categories of beneficiaries, and of the characteristics of certain aspects of the programs. Specific activities included:

- Study of postsurgical mortality of beneficiaries to increase understanding of factors influencing survival rates;
- Study of factors influencing disenrollment of beneficiaries from alternative health plans;
- Study of geographic variation in medical use and costs to increase understanding of factors influencing utilization patterns and factors influencing costs of services; and
- Study of the "cross-over" population that uses Medicare and Medicaid to increase understanding of the characteristics of this segment of the Medicare/Medicaid population.

Quality and Coverage

In order to assess the impact of program changes on the quality of care, as well as to ensure the continuation of quality of care provided to beneficiaries, it is essential that valid quality-of-care measures for different treatment settings be developed. Activities were planned that include:

- Refinement of hospital quality-of-care measures for use in determining absolute levels of quality and changes in quality over time;
- Studies of changes in access to hospital services over time; and
- Development of measures of appropriateness and quality of care for subacute care.

Because any expansion of coverage to include new benefits or services will have a potential impact on program expenditures and quality of care, it is imperative to continue to study selected coverage issues, as well as the potential impact of new technologies on treatment and service utilization for particular segments of the Medicare population. HCFA continued efforts in the following areas:

- Survival rates of end-stage renal disease patients, particularly focusing on the impact of treatment modalities on survival rates; and
- The effects of expanded coverage of alcoholism and mental health services.

Beneficiary Awareness and Prevention

There is a body of literature which indicates that spending for preventive health care services will reduce overall spending in the long run. Despite this evidence, third-party payers cover few, if any, preventive-care services. In addition, Medicare is precluded under present law from covering such services.

It is also important to conduct studies of how well beneficiaries understand the program and of the impact beneficiary awareness/education efforts have on program understanding, selection of health care alternatives, and selection of treatment modalities.

Studies were under consideration that would demonstrate and evaluate the extent to which preventive services and patient education efforts prevent, control, delay, or reduce morbidity from chronic diseases and reduce the overall cost of health care under the Medicare program.

HCFA's Research Publications Program

HCFA continued its research publications program through several series of publications that cover research and demonstration activities and statistical information on the Medicare program. These were part of a dissemination effort to reach interested user groups and to provide research results for policymakers and health professionals.

Information on the research publications program and the availability of various reports may be obtained from ORD Publications, Room 2-E-6 Oak Meadows Building, 6325 Security Boulevard, Baltimore, Maryland 21207.

CHAPTER 5. YEAR-END TABLES

PART A INTERMEDIARIES
TREND DATA AND INDICES,
FY 81 - FY 85
WORKLOAD AND COST

FY	Bills Processed	Administrative Cost	Total Cost
81	42,539,800	$234,615,400	$5.52
82	45,551,700	$231,930,900	$5.09
83	48,688,900	$261,824,200	$5.38
84	50,215,984	$295,691,780	$5.89
85	58,814,147	$336,298,361	$5.72
		INDICES	
81	100.0	100.0	100.0
82	107.1	98.9	92.2
83	114.5	111.6	97.4
84	118.0	126.1	106.7
85	138.3	143.3	103.6

PART A INTERMEDIARIES
TREND DATA AND INDICES,
FY 81 - FY 85
BENEFITS

FY	Benefits Paid (in Millions)	Benefits Paid Per Bill	Percent Administrative Cost to Benefits
81	$30,703,700	$721.76	0.8
82	$36,590,600	$803.28	0.6
83	$40,207,500	$825.80	0.7
84	$44,617,113	$888.50	0.7
85	$52,556,231	$893.60	0.6
		INDICES	
81	100.0	100.0	100.0
82	119.2	111.3	75.0
83	131.0	114.4	87.5
84	145.3	123.1	87.5
85	171.2	123.8	75.0

PART B CARRIERS
TREND DATA AND INDICES
WORKLOAD AND COST

FY	Claims Processed	Administrative Cost	Total Unit Cost
81	169,541,700	$450,537,700	$2.66
82	185,769,600	$458,819,500	$2.47
83	204,048,800	$485,833,300	$2.38
84	224,676,923	$515,833,214	$2.30
85	265,936,345	$599,188,551	$2.25
		INDICES	
81	100.0	100.0	100.0
82	109.6	101.8	92.9
83	120.4	107.8	89.4
84	132.5	114.5	86.5
85	156.9	133.0	84.6

PART B CARRIERS
TREND DATA AND INDICES
BENEFITS EXCLUDING PSRO AND EMO

FY	Benefits Paid (in Millions)	Benefits Paid Per Bill	Percent Administrative Cost to Benefits
81	$ 9,388,767	$55.38	4.8
82	$11,186,164	$60.20	4.1
83	$13,674,657	$67.02	3.6
84	$15,280,366	$68.01	3.4
85	$17,496,544	$65.79	3.4
		INDICES	
81	100.0	100.0	100.0
82	126.3	108.7	85.4
83	145.6	121.0	75.0
84	162.8	122.8	70.8
85	186.4	118.8	70.8

NATIONAL HEALTH CARE/SOURCE OF FUNDS

	Calendar Year					
	1965	1970	1975	1980	1984	1985
Total (billions)	$41.9	$75.0	$132.7	$248.1	$390.2	$425.0
	Percentage Distribution					
Total	100.0	100.0	100.0	100.0	100.0	100.0
Private Funds	73.8	63.0	57.5	57.6	59.1	58.9
Direct Patient Payments	44.1	35.3	28.7	25.4	25.1	24.9
Private Health Insurance	23.9	22.5	25.0	29.3	31.1	31.4
Philanthropy/In-Plant	5.8	5.1	3.8	2.9	2.9	2.7
Federal Government	13.2	23.6	27.9	28.6	28.6	29.3
Medicare	—	10.0	12.3	14.8	16.5	17.0
Federal Medicaid	—	4.0	6.0	5.8	5.3	5.5
Other Federal	13.2	9.6	9.7	8.0	6.8	6.8
State/Local Government	13.0	13.5	14.5	13.8	12.3	11.9
State Medicaid	—	3.3	4.7	4.8	4.5	4.4
Other State/Local	13.0	10.2	9.9	8.9	7.7	7.5

Source: HCFA/OACT

PERSONAL HEALTH CARE/PAYMENT SOURCE

	Calendar Year					
	1965	1970	1975	1980	1984	1985
Total (billions)	$35.9	$65.4	$117.1	$219.7	$341.1	$371.4
	Percentage Distribution					
Total	100.0	100.0	100.0	100.0	100.0	100.0
Private funds	78.0	65.7	60.5	60.6	60.7	60.3
Direct Patient Payments	51.6	40.5	32.5	28.7	28.7	28.4
Private Health Insurance	24.2	23.4	26.7	30.7	30.7	30.6
Other	2.2	1.7	1.3	1.2	1.3	1.3
Public Funds	22.0	34.3	39.5	39.4	39.3	39.7
Federal	10.1	22.2	26.8	28.4	29.6	30.3
State and Local	11.9	12.1	12.7	10.9	9.7	9.4

Source: HCFA/OACT

MEDICARE PERSONS SERVED/TYPE OF SERVICE - CALENDAR YEAR 1985

	Aged		Disabled	
	Persons Served* (in thousands)	Served per 1,000 Enrollees	Persons Served* (in thousands)	Served per 1,000 Enrollees
Hospital and/or Supplementary Medical Insurance	18,904	686	1,845	639
Hospital Insurance	6,496	240	700	243
Inpatient Hospital	6,195	228	674	234
Skilled Nursing Facility	290	11	9	3
Home Health Agency	1,398	52	100	35
Supplementary Medical Insurance	18,706	699	1,812	684
Physician and Other Medical	18,128	677	1,721	649
Outpatient	8,743	327	1,029	388
Home Health Agency	24	1	**	-

* Medicare enrollees who received a covered service for which: 1) Medicare Trust Fund payments were made and 2) Bills were received and processed in HCFA central office.

** Less than 500

Source: HCFA/BDMS

TOTAL HOSPITAL AND SUPPLEMENTARY MEDICAL INSURANCE ENROLLEES, 1966 - 1986
(In Millions)

July 1	HI &/or SMI	HI	SMI
1986 (proj.)	31.8	31.3	30.6
1985	31.1	30.6	30.0
1980	28.5	28.1	27.4
1975	25.0	24.6	23.9
1970	20.5	20.4	19.6
1966	19.1	19.1	17.7

NUMBER OF ENROLLEES, FY 85 - FY 86
(In Thousands)

Type of Coverage	1985	1986 (est)	Percent Change
HI &/or SMI			
Aged	28,176	28,826	2.3
Disabled	2,876	2,911	1.2
ESRD Only	31	31	0.0
Total	31,083	31,767	2.2
HI			
Aged	27,683	28,322	2.3
Disabled	2,876	2,911	1.2
ESRD Only	31	31	0.0
Total	30,589	31,263	2.2
SMI			
Aged	27,311	27,925	2.2
Disabled	2,649	2,669	0.8
ESRD Only	29	29	0.0
Total	29,989	30,623	2.1

MEDICARE BENEFIT PAYMENTS, FY 85
(In Millions)

Hospital Insurance

Inpatient Hospital	44,848
Skilled Nursing Facility	590
Home Health Agency	2,257
Hospice	15
	47,710

Supplementary Medical Insurance

Physician and Part B Suppliers	16,452
Outpatient	4,002
Home Health Agency	33
CPTPs	663
Independent Laboratories	658
	21,808

[redacted]
EQUAL EMPLOYMENT OPPORTUNITY PROFILE
FY 84 and 85

		FY 84	FY 85
A.	Workforce, FY 84	4,042	4,031
	Males	1,935 (47.9%)	1,925 (47.8%)
	Females	2,105 (52.1%)	2,106 (52.2%)
B.	Minority Workforce	1,011 (25%)	1,001 (24.8%)
	Blacks	847 (20.9%)	848 (21.0%)
	Hispanics	92 (2.2%)	88 (2.2%)
	American Indians	20 (.49%)	19 (.47%)
	Asian American	52 (1.3%)	54 (1.3%)
C.	Handicapped Workforce	39 (.96%)	40 (.99%)
	Males	23 (.57%)	24 (.59%)
	Females	16 (.39%)	16 (.39%)
D.	Female Workforce	2,107 (52.1%)	2,106 (52.2%)
	Minority	762 (18.6%)	759 (18.8%)
	Nonminority	1,345 (33.8%)	1,347 (33.7%)

TERMINATIONS, FY 85

Facility Type	Voluntary*	Involuntary	Total
SNFs	103	27	130
Hospitals	64	4	68
HHAs	312	3	315
OPTs	71	4	75
Labs	280	10	290
X-ray	18	0	18
ESRDs	12	0	12
RHCs	39	0	39
ASCs	10	0	10
Hospices	2	0	2
CORFs	11	0	11
TOTAL	922	48	970

*Includes mergers, closures, and voluntary withdrawals.

CHAPTER 6. REPORT ON MEDICARE VALIDATION SURVEYS OF JCAH-ACCREDITED HOSPITALS

Introduction

The purpose of the validation program is to determine the effectiveness of the Joint Committee on Accreditation of Hospitals (JCAH) accreditation process in providing reasonable assurance that hospitals comply with the intent of the Medicare Conditions of Participation. Each year, the Health Care Financing Administration (HCFA) selects a statistical sample of the approximately 5,100 JCAH-accredited hospitals for validation surveys. Under contract with the Secretary, State agencies (SAs) conducted 66 validation surveys during FY 85.

Statutory Background

Section 1865 of the Social Security Act provides that JCAH- accredited hospitals are deemed to meet the requirements of the Medicare Conditions of Participation, except for utilization review or other standards the Secretary promulgates that are higher than JCAH standards. Thus, JCAH-accredited hospitals are not subject to annual SA surveys to assess compliance with the conditions of participation. Subsection 1864(c) of the act authorizes the Secretary to enter into an agreement with any State to survey hospitals accredited by JCAH on a selective sample basis or in response to substantial allegations of significant deficiencies that affect the health and safety of patients.

Accreditation Process

The purpose of a JCAH accreditation survey is to assess the extent of a hospital's compliance with JCAH standards. After the completion of the onsite survey, JCAH makes an accreditation decision.

Prior to January 1, 1982, the maximum period of JCAH accreditation was 2 years, which was given to hospitals fully meeting JCAH standards. A hospital found to be in substantial compliance with JCAH standards, although demonstrating certain shortcomings, received a 1-year accreditation.

On January 1, 1982, JCAH discontinued both 1- and 2-year accreditations and changed its accreditation program to a 3-year accreditation with a "contingency" procedure. Under JCAH's new accreditation program, a hospital may receive a 3-year accreditation; a 3-year accreditation with a contingency; or in cases where a hospital fails to achieve substantial overall compliance, no accreditation. A contingency stipulates that the accreditation will be withdrawn if the hospital fails to correct its deficiencies within a specified amount of time.

JCAH, through the use of focused onsite resurveys and/or written reports prepared by the hospital, determines whether the hospital has corrected the deficiencies adequately to retain accreditation. The contingency accreditation process is analogous to a

Medicare resurvey, as they both assess correction of deficiencies. If corrections are not completed as specified in the contingency, the accreditation may be withdrawn. When JCAH increased its accreditation cycle to 3 years, it strengthened existing monitoring mechanisms to include periodic self-survey reports and/or focused onsite surveyor revisits.

In this report period, JCAH performed 1,536 surveys. Nine percent of the hospitals surveyed by JCAH (140 of 1,536) received 3-year accreditations without contingencies, 56 percent (865 of 1,536) received accreditations requiring written contingency reports, 10 percent (159 of 1,536) received accreditations requiring contingency onsite visits, and 23 percent (351 of 1,536) received accreditations requiring both written reports and onsite visits. Two percent (21 of 1,536) were not accredited. Thus, 89 percent of all accredited hospitals surveyed by JCAH during 1985 received contingencies (56 percent + 10 percent + 23 percent).

Validation and Allegation Process

HCFA selects, from scheduled JCAH accreditation surveys, a statistical sample of accredited hospitals for validation surveys. The random selection reflects the urban-rural mix of hospitals and the range of different sizes of hospitals. This permits HCFA to apply its findings to the universe of JCAH hospitals. SAs survey these hospitals using the Medicare Conditions of Participation for Hospitals. In FY 85, 80 percent of the hospitals in the validation survey had received contingent accreditation from JCAH.

An accredited hospital is also subject to an SA survey when there is an allegation that significant deficiencies threaten the health and safety of patients. Allegation surveys evaluate only the specified condition(s), as authorized by HCFA's regional offices. If a significant deficiency is found in the specified condition(s), the investigation is expanded to a full survey.

In both sample and allegation surveys, if significant deficiencies are found, the hospital is placed under SA surveillance until the deficiencies are corrected. The hospital is no longer deemed to meet the Medicare Conditions of Participation, and the SA monitors the correction of any deficiency as if the hospital were unaccredited.

Validation Findings

In FY 85, HCFA's analysis was conducted in two areas: Life Safety Code (LSC) and general health and safety requirements.

Life Safety Code

The LSC of the National Fire Protection Association is a consensus standard adopted by reference in Federal regulations that provides a reasonable level of safety from fire and other emergencies. During FY 85, 63 percent (42 of 66) of validated hospitals were in compliance with the LSC (see Table 1). For all hospitals validated prior to this report period, 49 percent (408 of 831) were in compliance with the LSC.

TABLE 1

Validation Surveys
Accredited Hospitals Found in Compliance By Medicare State Survey Agencies

		All Previous Report Periods		FY 85	
		No.	%	No.	%
General Health and Safety	In Compliance	757	91	53	80
	Total Surveys	831		66	
Life Safety	In Compliance	408	49	42	64
	Total Surveys	831		66	

This increase in LSC compliance can be attributed to Medicare's adoption of the Fire Safety Evaluation System (FSES) for conducting validation surveys and the improved effectiveness of JCAH surveyors in assessing compliance with the LSC by using the 1981 code. The FSES was developed by the National Bureau of Standards and is a method for assessing compliance with LSC requirements. The FSES permits a facility to employ alternative measures for meeting LSC requirements while providing an equivalent level of fire safety. Since adoption of the FSES, there is more similarity between the JCAH and Medicare LSC surveys because both are using FSES.

Also, in FY 85, JCAH surveyed all facilities for compliance with the 1981 LSC. The 1981 code relies more heavily than did earlier codes on early detection and prompt notification of the fire department. HCFA is developing regulations that would require adoption of the 1981 LSC for all providers.

HCFA noted that JCAH cited many deficiencies for inadequate latching of patient room doors and for deficient doors. These types of deficiencies could prove to be serious, especially in buildings without sprinklers. HCFA also noted Medicare citations without corresponding JCAH citations for unprotected vertical openings and lack of firestopping.

Over the years, JCAH surveyors have increased citations pertaining to integrity of doors, walls, ducts, and smoke barriers, and they continue to cite these important deficiencies. HCFA noted no deficiencies for unprotected vertical openings and penetrations of fire walls, including ceilings, particularly by pipe chases. These deficiencies should be noted, particularly in older buildings.

HCFA noted both JCAH and Medicare deficiencies on sprinklers. Sprinkler systems must include a check of the inspector's test valve, electrical supervisor, and water-flow

alarm. All sprinkler systems must be connected to the fire alarm, and the fire alarm must be connected to the fire department or outside service.

Medicare recommended in 1980 that JCAH surveyors receive additional training in surveying for smoke barriers. These construction requirements are important because the smoke barriers limit the spread of smoke and toxic gases. Inhalation of these gases is the most frequent cause of death in fires. As demonstrated by JCAH citations in smoke-barrier deficiencies, there continues to be improvement in surveying for compliance with this requirement.

General Health and Safety

During this report period, Medicare found 80 percent (53 of 66) of JCAH-accredited hospitals receiving validation surveys in compliance with general health and safety conditions (see Table 1). This is consistent with the range of percentages in compliance (80-96 percent) in all previous report periods.

With respect to the general health and safety conditions for validated hospitals, the frequency of noncompliance was evenly distributed over the 14 conditions, occurring between zero and four times (0-6 percent) in the sample group (see Table 2).

In the universe of unaccredited hospitals, the frequency of noncompliance was also distributed evenly over the 14 conditions, occurring between 15 and 92 times (1-6 percent) (see Table 2).

TABLE 2

Sample Noncompliance Compared to Unaccredited Universe Noncompliance

Condition	Sample Noncompliance		Unaccredited Universe Noncompliance	
	Frequency	%	Frequency	%
State and local law	2	3	64	4
Governing body	2	3	58	4
Physical environment	2	3	81	5
Medical staff	4	6	69	4
Nursing	2	3	92	6
Dietary	0	0	32	2
Medical record	3	5	56	3
Pharmacy	3	5	77	5
Laboratories	3	5	89	6
Radiology	0	0	18	1
Complementary	2	3	21	1
Outpatient	0	0	23	1
Emergency	3	5	88	6
Social work	0	0	15	1

CHAPTER 7. MEDIGAP VOLUNTARY CERTIFICATION PROGRAM REPORT

Background

Congressional studies conducted prior to 1980 found many abuses in the sale and marketing of Medicare supplement or "Medigap" health insurance. There were no Federal standards for Medicare-supplement coverage, and few States had adopted programs specifically to regulate these types of policies. In June 1980, Congress enacted Public Law 96-265, which added section 1882 to Title XVIII of the Social Security Act.

Initially, insurance regulators and the insurance industry staunchly opposed this law, usually referred to as the Medigap law. The regulation of the business of insurance has traditionally been the responsibility of the States under the McCarran-Ferguson Act of 1945, and the Medigap law was perceived by some as an encroachment upon States' rights. This perception resulted from a fear that the Federal Government would necessarily become greatly involved in individual insurance department operations in order to enforce the law. This has not proved to be the case, however, and the relationship between the Federal Government and the States has been a cooperative one. State and Federal agencies are working together toward the common goal of providing the best protection available for elderly citizens.

Provisions of the Medigap Law

The Medigap law established Federal minimum standards based primarily on the provisions contained in the 1979 National Association of Insurance Commissioners (NAIC) Model Regulation To Implement the Individual Accident and Sickness Insurance Minimum Standards Act. The law, however, expands upon the model's requirements by extending its jurisdiction to certain group policies and by adding loss-ratio requirements for both group and individual policies. In addition, it provides for the establishment of the Supplemental Health Insurance Panel and a Federal Voluntary Certification Program for Medicare supplement policies, and it includes criminal penalty provisions for certain abusive sales practices.

The law also requires the Secretary of the Department of Health and Human Services (DHHS) to submit to Congress no later than July 1, 1982, and periodically as may be appropriate thereafter (but not less than once every 2 years), a report evaluating the effectiveness of the certification procedure and the criminal penalties established under this section.

The Voluntary Certification Program

Under the Voluntary Certification Program, insurers selling Medigap policies not approved by the Supplemental Health Insurance Panel may voluntarily submit such policies to be reviewed by the Secretary of DHHS. Those policies found to meet or exceed the Federal minimum standards will be certified, and the insurer will be

authorized to display a Federal emblem on the policy. The emblem is authorized for use only in States subject to the Federal program, regardless of whether the same policy is marketed in States not under the program.

Participation

The Supplemental Health Insurance Panel determined that the Voluntary Certification Program should be implemented in four States (Massachusetts, New York, Rhode Island, and Wyoming) and three territories (Guam, the Virgin Islands, and American Samoa).

Only two insurers have submitted policies for review under the Voluntary Certification Program, and no policies have been certified to date. Although the deficiencies noted in the policies submitted were seemingly minor, the insurance companies involved have not resubmitted the policies nor indicated that they have made the necessary changes.

The fact that the Voluntary Certification Program applies only to a very few States and jurisdictions in itself limits the program's direct impact. At the same time, however, the Voluntary Certification Program was responsible for the overwhelming success of the Medigap law, since it served as an incentive for such a large number of States to adopt their own programs regulating Medigap policies. Indeed, the number of States adopting the 1979 NAIC Model is the largest ever to adopt any NAIC model.

In addition to the small number of States involved, there are other possible reasons for such a limited reaction to the program. Foremost is the perception on the part of State insurance regulators and the insurance industry that such a program is an infringement upon the individual State's right to regulate the business of insurance.

As was noted earlier, the Federal-State relationship resulting from the Medigap law has proved an amiable one, but there is still much apprehension in the insurance community about a "Federal" emblem being placed on a private insurance policy. It is felt that the emblem may encourage the practice of "twisting," where insurance agents replace existing coverage with new coverage that offers no greater benefits or even lower overall benefit levels.

Some insurers also feel that the emblem may confuse some elderly Medicare beneficiaries, since it would be permitted to appear only on those policies sold in States subject to the Voluntary Certification Program. Most insurers design their Medigap policies to be marketed in a number of States. So a situation would exist where a policy would be able to display the emblem in a State under the Federal program, but the exact same policy could not bear the emblem in a State that was not under the program. The additional cost involved in preparing policies for distribution in just a few States also is a deterrent to seeking certification.

Impact

Since the Secretary has not yet certified any policies under the Voluntary Certification Program, there are no data available to show the direct impact of the certification procedure on market share, value, and cost to individuals entitled to benefits under Title XVIII. As stated earlier, however, the indirect impact of the program has been its very positive effect of prompting States to implement their own approved regulatory programs for Medicare-supplement policies. Without the incentive provided by the Voluntary Certification Program, it is doubtful that as many States would have changed their existing programs. Also, the Supplemental Health Insurance Panel is now responsible for monitoring the continued compliance of the approved States, and the Voluntary Certification Program should act as a deterrent to those States considering changes to their regulatory programs that would adversely affect their continued compliance with the Medigap law.

Penalty Provisions

The Medigap law also established Federal criminal penalties for certain fraudulent or abusive marketing practices. Section 1882(d) provides criminal sanctions for furnishing false or misleading information for the purpose of obtaining certification; for misrepresentation as an agent of the Federal Government for the purpose of selling insurance to supplement Medicare; for knowingly selling insurance which substantially duplicates benefits of another policy held by the purchaser; and for knowingly advertising, soliciting, or offering for sale mail-order polices in a State without the approval of the State insurance commissioner. Anyone convicted of violations of section 1882 is subject to a fine of up to $25,000 and/or imprisonment for up to 5 years.

Implementation

The Health Care Financing Administration (HCFA), given the responsibility for implementing the penalty provisions of the Medigap law, continues to investigate possible violations of section 1882(d). HCFA has developed a system of coordination for reporting these violations that includes the 10 HCFA regional offices, the Social Security Administration, the Office of the Inspector General (OIG) for the Department of Health and Human Services, and the Department of Justice (DOJ).

The initial screening of complaints is generally done through HCFA's regional offices. These offices are also responsible for furnishing information to State insurance departments about specific complaints. The OIG investigates complaints that have been referred to them by HCFA and coordinates this activity with State insurance departments. OIG also serves as the liaison between State insurance departments and the U.S. Attorneys, who have been contacted by the Fraud Division of DOJ regarding the Medigap law and encouraged to prosecute violations of this section

HCFA also receives many complaints about practices which, while not in violation of the Medigap law, are possible violations of other Federal statutes. These most often involve misleading advertising and mail-order solicitations for Medicare-supplement insurance. HCFA's efforts in this area are being coordinated with other Federal agencies such as the Federal Trade Commission and the Postal Inspection Service.

Activity in FY 85

During FY 85, HCFA was informed of 17 possible violations of the penalty provisions. All of the cases involved section 1882(d)(2), which prohibits a person from falsely representing an association with the Medicare program or any Federal agency for the purpose of selling or attempting to sell health insurance. Of the complaints received, 4 are being investigated by specific State insurance departments and 13 were closed by HCFA due to lack of evidence.

Additionally, HCFA was able to close out seven cases which were pending from prior fiscal years.

Difficulties in Prosecution

Witness reliability has continued to be a problem in getting cases prosecuted under section 1882. The elderly often become confused under questioning, and prosecutors are reluctant to charge agents under Federal law, since criminal penalties are called for. They feel that administrative penalties are more appropriate in many cases.

There is still interest at the State level in utilizing Federal penalties to prevent abuse and fraud in the sale and marketing of Medigap policies. Most States still do not have specific laws for violations involving Medicare-supplement health insurance. As was indicated, however, getting these types of cases prosecuted under Federal law has proved difficult, and there have been no convictions to date under this law. At the present time it is felt that it is in the best interest of elderly citizens to continue the penalty provisions of section 1882, to keep available the option of prosecution under Federal law.

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